

Arkansas HIE Player/Payer	What is cost now? ALL COSTS – \$/time/etc.	FINANCIAL incentives/savings to be realized with HIE	Estimated \$/% value of FINANCIAL incentives	Notable FINANCIAL Disincentives/barriers
Individuals – Patient/Consumer	<ul style="list-style-type: none"> - pay fee to get personal copies of medical records - time spent to follow/track medical records/health issues - time spent to report health info/history to multiple providers - pay directly (co-pay, full payment, etc.) for duplicate tests - pay indirectly for duplicate services (tests, collection of health history, other data) with increased health care costs – provider costs go up as well as insurance costs 	<ul style="list-style-type: none"> - possible decrease in direct costs to obtain medical records <p>PHYSICIANS WILL LIKELY CONTINUE TO CHARGE PTS FOR MEDICAL RECORDS</p> <ul style="list-style-type: none"> - possible decrease in overall/indirect costs, but will take a long time to see - decrease in direct costs for uninsured/underinsured if/when duplicate tests decrease - CERTAINLY SHOULD BE NOTED ON THE PLUS SIDE. WOULD POSSIBLE REDUCE COSTS FOR INSURED AS WELL 	<ul style="list-style-type: none"> - savings possibility if electronic records cost less to access - time savings for collection of health information - more value to those who use system more - more immediate value to uninsured or underinsured because they pay more in direct costs 	<ul style="list-style-type: none"> - patients could be good advocates for HIE, but direct costs may not be the best incentives for them to support it – improved health, ease of health care use, time savings all seem to be better places to look for support
Public Health	<ul style="list-style-type: none"> - pay to track required health issues (Where do the agencies get the \$ to pay for access now? Is this an indirect cost to the taxpayer?) 	<ul style="list-style-type: none"> - Timely and more accurate reporting; freeing staff to analyze disease trends. 	<ul style="list-style-type: none"> - Savings in staff cost from more efficient streamlined process could be sizable. 15% maybe. 	<ul style="list-style-type: none"> - User fee if higher than current costs, particularly if not offset by some savings.

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	<p>- ADH maintains T1 lines to each hospital for emergency preparedness (federal funding) - those funds are expected to diminish possibly leaving the state without its hospital network; approximate annual cost \$900K</p> <p>- Built in cost for many different systems and staff to manage data</p> <p>- costs to manage many systems, platforms, contracts</p>	<p>- Incentive would be to preserve the public health emergency preparedness network.</p> <p>- Will it cost them less (to track health issues)? Will they be able to get more data? More accurate data? Easier? Quicker? Security issues to be addressed.</p> <p>- STATS COULD BE USED TO TARGET AREA IN STATE WITH POOR PERFORMANCE RECORDS FOR IMMUNIZATIONS, MAMMOGRAMS, ETC</p> <p>- Streamlined processes could increase accuracy, credibility, and decrease lag time for data submission</p> <p>- Possible single source for data to be submitted and queried could mean a cost savings in training, support and conversion of data coming into and going out of the system.</p>	<p>- Guess would be 5% savings going from multiple systems and sources converted to a single format, and one data base</p> <p>- more timely reporting; better mgmt of/access to critical PH data</p>	<p>- Legacy process has know expenses while new process could have unknown expenses.</p> <p>- If savings exist then sunk cost of existing system would keep some from being willing to adopt a new process.</p> <p>- concerns about control of data access, use, etc.</p>

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		-more efficient access for providers; more integrated data systems/support		
Medicaid	<p>- Provision of software for claims processing; Training of clinic staff to use (Will claims transmittal and processing be a part of the HIE processes?); Payment for duplication of tests, Payment for medical care as a result of treatment not being coordinated and conflicts arising; Payment for claims processing-volume should be decreased if duplications avoided.</p> <p>- Low levels of active effective diabetic management are currently costing the plan millions in added hospital expenses</p> <p>- payment to MMIS contractor</p> <p>- duplicate services; lack of integrated tracking across services & providers</p>	<p>- If providers could access all recent testing data from all sources as they treat the patient, proper tracking and screening tests (A1c) could be performed and more active management of the patient's condition could result in less hospitalization. Lower hospital cost could be a significant savings to the plan.</p> <p>- conserve declining GR; reduce overutilization, waste, fraud; reallocate funds for better health outcomes</p>	<p>- CMS reported between 2-8% cost savings with HIE (at DC conference in Feb 2010)</p> <p>- Even a 10-15% reduction in the hospital cost just for the diabetic members could be a sizable savings to the bottom line.</p>	<p>- Depends on fee structure developed and perceived value and fairness. Voluntary or mandatory payments? If offset by operations and claims savings, should work.</p> <p>- Providers would have to incur no cost from the HIE for accessing the records for these patients. The Plan might pay more for screening tests in the early years of adoption.</p> <p>- need to navigate fed rules/regs; control and oversight management concerns</p>

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Other State Agencies & Programs	<p>- How are they accessing and using health data now? Is participation by providers mandatory or voluntary? Is there reimbursement to the provider for the cost of providing data? How are agencies paying for the data?</p> <p>- State Ins. Dept-better access to data for regulatory oversight</p>			- User fee if higher than current costs, particularly if not offset by some savings.
Self-Funded Employer Health Plans (ie Employee Benefit Division, etc.)	- overutilization, duplicate tests, procedures; failure to manage high cost/chronic care	- reduce overutilization, waste, fraud; reallocate funds for better health outcomes		- need to see positive ROI; assess PM/PM impact
Private Insurers	<p>- pay for duplicate tests for insured</p> <p>- pay to have access to some health care data to do statistical analysis</p> <p>- Pay for processing increased claims</p>	<p>- COST SAVINGS TO INSURERS BUT IF PROVIDERS DO NOT ACCESS SYSTEM AND PERFORM A DUPLICATED TEST PHYSICIAN LOSES IF DEEMED AS NOT MEDICALLY NECESSARY</p> <p>- reduce overutilization, waste, fraud; reallocate funds for better health outcomes</p>	- pay less out because services are being used less	- need to assess impact on premiums

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	- failure to manage high cost/chronic care			
Labs	<p>- Public health reporting requirements</p> <p>- Who bears the costs of interfacing with the clinic/hospital sites now for the transmission of test results? Does it cost the lab each time a new clinic/hospital wants to link up and get results electronically?</p> <p>- inefficient results info; potential for ID errors/reports</p>	<p>- Easier, more accurate, less costly reporting</p> <p>- If the lab just has one interface to maintain, will this save them money?</p> <p>- more efficient results reports; reduce ID & reporting errors</p>		- less income when duplicate tests decrease
Physicians – Primary Care	- may have to cover costs of duplicate tests, etc. for uninsured	- if able to access tests performed at other institutions, may be able to save – but probably only for uninsured		- less income when duplicate tests decrease (though may be = to time saved/lost)

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	<p>- Office visit may be delayed due to waiting for medical records from some other provider. There is an operational cost to be had if visit space saved, then patient not seen due to above issue and then must reappoint patient. More operational cost to ensure get medical record from some other provider.</p> <p>- Treatments may not be coordinated effectively due to not having all medical information on a patient- sometimes telephone triage cost is a result as patient calls in with issues.</p> <p>- Also operational costs to provide medical records to other providers.</p>	<p>- PRIVATE PAYERS MAY DENY DUPLICATES AND NOT PAY PHYSICIANS WOULD HAVE TO EAT THE COST</p>		<p>- User Fees</p> <p>- Who provides the \$ to link to HIE? (Interface, staff time, equipment, supplies, space, utilities)</p>
Physicians – Specialists	<p>- may have to cover costs of duplicate tests, etc. for uninsured</p>	<p>- if able to access tests performed at other institutions, may be able to save – but probably only for uninsured</p>		<p>- less income when duplicate tests decrease (though may be = to time saved/lost)</p>
Clinics	<p>- may have to cover costs of</p>	<p>- if able to access tests</p>		<p>- less income when duplicate tests</p>

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	duplicate tests, etc. for uninsured	performed at other institutions, may be able to save – but probably only for uninsured		decrease (though may be = to time saved/lost)
Hospitals	- may have to cover costs of duplicate tests, etc. for uninsured - Public health reporting requirements	- if able to access tests performed at other institutions, may be able to save – but probably only for uninsured - Easier, more accurate, less costly reporting. Able to redirect infection control personnel to preventing disease.		- less income when duplicate tests decrease (though may be = to time saved/lost)
Other Providers	- may have to cover costs of duplicate tests, etc. for uninsured			- less income when duplicate tests decrease (though may be = to time saved/lost)
Data Users/Research ers	- great deal of expense to identify and then access data from needed cohorts	- GOOD STREAM OF POSSIBLE REVENUE, GENERAL POPULATION BE CONCERNED ABOUT WHO/WHY DATA IS BEING ACCESSED, SHOULD NOT BE USED BY PRIVATE PAYERS TO DENY COVERAGE		
Community/Ge neral	- time spent collecting data from patients multiple times			

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Other: Pharmacy	<ul style="list-style-type: none"> - Not filling prescriptions following review of current prescriptions. - Less prescriptions filled less time of pharmacists for improper fills 	<ul style="list-style-type: none"> - Able to track and review all medications being currently prescribed for all patients before filling duplicate/redundant or conflicting prescriptions. 	<ul style="list-style-type: none"> - Possible lower cost to meet the federal requirements for drug interaction and Class restricted drug reviews prior to dispensing. 	<ul style="list-style-type: none"> - Other products or programs may be in place or may undercut the HIE cost.